NEBRASKA COMPREHENSIVE HEALTH INSURANCE POOL

This policy, developed pursuant to the Comprehensive Health Insurance Pool Act, is made in and governed by the laws of the State of Nebraska.

This policy consists of your application, your schedule of benefits, this document, and any endorsements thereto. It provides one-person coverage, for you, the insured person only.

This policy is a Preferred Provider Organization (PPO) benefit plan, providing benefits for the health care services described, defined and limited herein, during the term of this policy. The Physicians, Hospitals and other providers within the Preferred Provider Organization have agreed to furnish services to covered persons in a manner reasonably expected to manage health care costs.

Nebraska Comprehensive Health Insurance Pool

By: H E Red Tibault

Chairman, Board of Directors

PART I. EFFECTIVE DATE AND RENEWABILITY

Your coverage starts on the policy date at 12:01 a.m. Standard Time, at your principal place of residence. Your policy date is shown on your Schedule of Benefits. This policy will be renewed each month by paying the premium within the 31-day grace period. This policy may be canceled if you fail to pay your premium when due, or for the reasons stated in Part V.

PART II. PLEASE READ APPLICATION

A copy of your application is attached. Please read the copy of your application. If anything is not correct or incomplete, you must tell us. Your policy was issued on the basis that all information in the application is correct and complete. If it is not, your policy may not be valid, or a claim may be reduced or denied.

PART III. 10-DAY RIGHT TO EXAMINE POLICY

Please read your policy. If you are not satisfied for any reason, send it back to us within 10 days after you receive it. If returned, any premium paid will be refunded, and the policy will be void and considered to never have been issued.

NEBRASKA CHIP

PPO INSURANCE POLICY

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PART IV. PREMIUM CHANGES

Your premium is based on factors such as gender, age, geographic area, as well as the coverage option elected by you. The amount of your monthly premium may change for the following reasons:

A. BECAUSE OF AGE: Based on your attained age, the premium will change each year. This change will only be made on the renewal date that coincides with or next follows each anniversary of the policy date.

B. GEOGRAPHIC AREA: As your premium is based in part on your geographic location (zip code), we reserve the right to adjust the amount of your premium if you move to a different zip code, within the state. This change will be effective on the next monthly due date following receipt of notice of the address change.

C. REVISED RATE SCHEDULE: In addition to the premium change described above in paragraphs A. and B. of this Part, the premium may also change on the basis of a revised schedule of rates. Such a change will be applied only when the same change is made on all policies of this form, with the same provisions and benefits, issued to persons of the same classification living in the same geographic area of Nebraska at the time of change. The change may be made on any renewal date.

PART V. GRACE PERIOD; CANCELLATION; TERMINATION; AND CONVERSION

A. GRACE PERIOD: **Premium payments are due on the first day of the month.** A grace period of 31 days will be granted for the payment of monthly premiums, during which grace period, the policy will remain in force. Subject to the grace period, if you fail to pay premiums, your policy ceases effective as of midnight of the last day for which premium has been paid.

B. All insurance will cease:

1. On the date we decline to renew all policies issued on this form subject to approval by the Director of Insurance;

2. On the date you

   a. become eligible for Medicare based on turning age 65,

   b. become eligible for Medicaid,

   c. become a resident or inmate of a correctional facility,

   d. are no longer a resident of Nebraska, or

   e. have been paid one million dollars ($1,000,000) in benefits from all CHIP policies which have ever been issued to you;

3. On the date of your death;

4. On nonpayment of premiums when due, subject to the grace period clause in Part V.A.;

5. On the date we receive a request from you to terminate the policy or any later date stated in your request.

We will provide written notice to you by certified or registered mail at your last known address, as shown on our records, thirty (30) days prior to the date we decline to renew the policy.

In cases of fraud or misrepresentation in claims for benefits, coverage will cease upon the date we give notice to you or any later date designated by us. In cases of fraud or misrepresentation of your eligibility for coverage, your coverage may be rescinded and will be considered to have never been issued.

You may terminate this policy by notifying us in writing. Following such notification, your policy will cease at the end of the period for which premiums have been paid. If you request an earlier termination date, your policy will cease on the later of your request date or the date we receive notification.

We will refund any premium paid and not earned if your policy ends. Termination will not affect any claim for services provided prior to the date your policy ends.

NOTE: If your policy ceases pursuant to 4. or 5. above, you are not eligible to apply for CHIP coverage until 12 months has elapsed since your policy ended, except as otherwise provided by state law.

C. CONVERSION PRIVILEGE: If your policy is terminated pursuant to Part V.B.1. above, we will issue you a new policy, on the form then being issued to new enrollees of CHIP. The coverage will be major medical, containing similar benefits as this policy. The premium will be based on your original issue class and your current age.

The first premium for such conversion coverage must be received by us within 31 days after this policy ends. Coverage will begin the day after this coverage ends. Any waiting periods set forth in the new policy will be considered as being met to the extent they were met under this policy.

PART VI. BENEFITS OVERVIEW

A. PAYMENT FOR SERVICES: This policy provides benefits for Covered Services provided to you, subject to Part XXIII., Exclusions and Limitations. For benefits to be payable by us, all Covered Services must be Medically Necessary. The benefit payment is determined by the following guidelines:

1. **PPO Providers:** Our Administrator has contracted with a panel of PPO Providers consisting of Physicians, Hospitals, and other health care providers, to furnish services to you in a manner reasonably expected to effectively manage health care costs, through a Preferred Provider Organization. The Preferred level of benefits will be available when services are provided by a PPO Provider. This means the Deductible and Coinsurance you pay will usually be less when Covered Services are received from PPO Provider. The PPO Providers agree to accept our payment, plus your payment of any Deductible and Coinsurance and any charges for Noncovered Services, as payment in full.

a. PPO Hospital: If you receive care in a PPO Hospital or Treatment Center because of Sickness, Injury, or Mental Disease or Disorders or Alcoholism or Drug Dependency, payment will be made to that Hospital or Treatment Center for Medically Necessary Covered Services. The Administrator has contracted with PPO Hospitals for payment of services at a Contracted Amount. This Contracted Amount may be based on a Diagnosis Related Group (DRG) assigned to the claim. One of the following methods of benefit payment for Hospital services will be used: 1) a specified reimbursement amount less a negotiated percentage discount; 2) a set amount per day (per diem) less a negotiated percentage discount; 3) charges for Covered Services less a negotiated percentage discount; 4) the lesser of charges for Covered Services or the fee schedule amount; or 5) any other appropriate manner agreed upon by the Administrator and the Hospital.

You are responsible for the payment of the Deductible and the Coinsurance, and charges for any Noncovered Services. A PPO Hospital has agreed to accept your Deductible and Coinsurance plus our benefit payment as payment in full for Covered Services.

b. PPO Physician or Other PPO Provider: A PPO Physician or other PPO Provider has entered into an agreement with the Administrator that he or she will accept payment of the lesser of the billed charge or the amount listed on the Provider Reimbursement Schedule, as payment in full for Covered Services. If the Covered Service is not listed on the Schedule, the PPO Provider has agreed to accept payment of the lesser of the billed charge or the Maximum Benefit Amount as payment in full for Covered Services.

You are responsible for the payment of the Deductible and the Coinsurance, and charges for any Noncovered Services. A PPO Provider has agreed to accept your Deductible and Coinsurance plus our benefit payment as payment in full for Covered Services.

c. If a claim is submitted for a service which is not approved by Utilization Review, the PPO Provider agrees not to charge, collect, or seek collection from you or from us, except as set forth in Part VI.A.4.

2. **Non-PPO Providers:**

a. Non-PPO Hospital: If you are confined as an Inpatient in a Non-PPO Hospital or Treatment Center because of Sickness, Injury, or Mental Disease or Disorders or Alcoholism or Drug Dependency, benefits are payable for precertified Covered Services. The Allowable Charge will be reduced by the Non-PPO Deductible and Coinsurance. You are responsible for payment of the Deductible, Coinsurance, and any charges for Noncovered Services.

As set forth in Part VII.A.1., if you fail to request precertification of benefits for an Inpatient admission to a Non-PPO Hospital or for any Inpatient admission for the treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency (at either a PPO facility or Non-PPO facility), the Allowable Charges for all related Covered Services will be reduced by 25%. You will be responsible for payment of the amount of the reduction.

b. Non-PPO Physician or other Provider: Benefits for Covered Services will be paid based on the lesser of the Provider's billed charge or the Maximum Benefit Amount. The Allowable Charge shall be reduced by the Non-PPO Deductible and Coinsurance. You are responsible for the payment of the Deductible, Coinsurance and any amount charged by the Provider which is in excess of the Maximum Benefit Amount for that Covered Service. You are also responsible for payment for any Noncovered Service.

As set forth in Part VII.A.1., if you fail to request precertification of benefits for an Inpatient admission as required, the Allowable Charges for all related Covered Services will be reduced by 25%. You will be responsible for payment of the amount of the reduction.

c. EXCEPTION: If you receive initial Inpatient or Outpatient care at a Non-PPO Hospital or by a Non-PPO Physician or Provider for an Emergency Medical Condition, benefits will be paid for Medically Necessary Covered Services subject to the PPO Deductible and Coinsurance rates for the initial care.

d. If the Non-PPO Hospital, Non-PPO Physician or other Non-PPO Provider has contracted with the Administrator under another type of participating arrangement, payment will be made pursuant to that arrangement. The Hospital will be reimbursed based on 1) a specified reimbursement amount; 2) a per diem; 3) charges for Covered services less a negotiated percentage discount; 4) the lesser of charges for Covered Services or the fee schedule amount; or 5) any other manner agreed upon by the Administrator and the Provider, as applicable. The Physician will be reimbursed based on the lesser of the Maximum Benefit Amount or billed charges. These Participating Providers have agreed to accept our payment, plus your payment of the Non-PPO Deductible and Coinsurance as payment in full for Covered Services. You are responsible for payment of any Noncovered Services.

e. You may contact the Administrator to determine the Maximum Benefit Amount for a specific procedure code for an Inpatient procedure at the time that you precertify that procedure.

3. **Payment to Out-of-Area Providers:** Blue Cross and Blue Shield of Nebraska, the Administrator for the Pool, participates in a national program through the Blue Cross and Blue Shield Association, called the BlueCard Program. Payments made for Covered Services under this policy by a Blue Cross and Blue Shield Plan in another state (on-site Plan) for claims processed through the BlueCard Program, may take advantage of any contractual arrangement between that Plan and its participating providers. If you contact Blue Cross and Blue Shield of Nebraska prior to incurring out-of-area services, information regarding specific participating providers may be available.

Insured person's liability: The method of calculating the Coinsurance for Covered Services for claims incurred outside Blue Cross and Blue Shield of Nebraska geographic service area typically will be at the lower of the provider's billed charge or the negotiated amount the on-site Blue Cross and/or Blue Shield Plan passes on to Blue Cross and Blue Shield of Nebraska.

Variance from state to state: The negotiated amount paid by Blue Cross and Blue Shield of Nebraska to the on-site Blue Cross and/or Blue Shield Plan for health care services may represent either a) the actual price paid on the claim or b) an estimated price that reflects adjusted aggregate payments expected to result from settlements with all of the on-site plan's health care providers or c) a discount from billed charges representing the on-site plan's expected average savings for all of its providers or for a specified group of providers.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over or underestimation of past prices.

In addition, statutes require Blue Cross and/or Blue Shield Plans in a small number of states to use a basis for calculating the insured person's liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. Thus, when Covered Services are received in these states, liability for Covered Services will be calculated using these state's statutory methods.

4. **Utilization Review:** Services provided by Hospitals, Physicians and all other health care providers are subject to Utilization Review. Utilization Review is the evaluation by the Administrator of the use of a medical, diagnostic, or surgical procedure or service or the utilization of medical supplies, drugs or Home Medical Equipment compared with criteria established by the Administrator in order to determine benefits. Benefits may be excluded for services, procedures, supplies, drugs or Home Medical Equipment found by the Administrator to be not Medically Necessary. PPO Providers have agreed that you will not be responsible for the charges for services which are determined to be not Medically Necessary. If a claim is submitted for a service which is not Medically Necessary, the PPO Provider agrees not to charge, collect or seek collection from you or us. If benefits for a service by a Non-PPO Provider are denied by Utilization Review and that provider does not have a participating arrangement with the Administrator, you will be responsible for payment of the charge.

EXCEPTION: The PPO Provider may collect from you, however, for a specific service, procedure, drug, supply or item of medical equipment where benefits are not payable pursuant to Utilization Review if, prior to the services being provided, the Provider has advised you, in writing, and you have agreed in writing to be responsible for the payment. If written agreement cannot be obtained, prior verbal notification may be given by the Provider and must be documented in the patient's medical record at the time that such notification is given. Use of this procedure must be limited to a specific instance and not done as a usual practice.

5. **Expansion of Benefits:** The Administrator may expand the scope of benefits in an individual case to include payment for specific services which would not ordinarily be included as Covered Services if it appears to us that use of such services will reduce costs, improve the quality of care or will be more appropriate than an alternate Covered Service. The Administrator will advise you and the provider in writing when, and to what extent, payment of such services will be made. Such expansion of the scope of benefits will not constitute an amendment to this policy, nor provide a continuing right to receive such services.

6. We reserve our Administrator's right to change or terminate their Agreements with health care providers and to alter benefit payment procedures to PPO Providers. Benefit payments may be calculated on a charge basis, a per diem basis, a global fee basis, a Maximum Benefit Amount or similar charge, through a Preferred Provider Organization, or in any other manner agreed upon between the Administrator and the provider. However, any payment method agreed to between the Administrator and the providers will not affect the method of calculating your Deductible, Coinsurance and Out-of-Pocket Expense Amount.

7. All payments for Covered Services provided by PPO Hospitals, PPO Physicians and other PPO Providers, or any provider who is participating with our Administrator pursuant to any other reimbursement program, will be made directly to such Participating Providers. In all other cases, payments will, at our option, be made to you, your estate, or the provider. No assignment for services which are provided within the state of Nebraska, whether made before or after services are provided, of any amount payable according to this policy shall be recognized or accepted as binding upon us.

8. All benefits payable under this policy will be paid as soon as possible after the claim has been filed.

9. This Policy provides one-person coverage, for you, the insured person only. This policy shall also provide coverage for your newly-born child, from the moment of birth, for a period of 31 days. The coverage for the newly-born child shall include coverage of Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage under this policy for the child shall terminate at the end of the 31-day period, unless the policy is terminated prior to that date.

10. MEDICAL RECORDS: In consideration for the processing of claims, the Administrator will be entitled to receive without charge, from you and all providers of services, such facts, records, and reports about the examination or treatment of you as may be needed to process claims or to determine the appropriateness of benefit payment.

PART VII. COST CONTAINMENT PROVISIONS

Certain provisions are included in your policy which are designed to reduce the total cost of medical care for your Covered Services due to Injury or Sickness.

These provisions may:

REQUIRE you to receive approval from the Administrator, before benefits are payable for Covered Services;

REQUIRE you to receive approval from the Administrator before benefits are payable for Covered Services at greater benefits or without a Deductible; or

ALLOW you to receive greater benefits if certain services or supplies are used.

A. **The following are mandatory requirements:**

1. **Preadmission or Admission Certification and Concurrent Review:** Certification authorizes payment of benefits for an Inpatient admission based on a review and assessment by the Administrator of the Medical Necessity of the admission. The appropriateness of the setting and level of care is assessed along with the timing and duration of the treatment. Certification is not a guarantee of payment, but is subject to the other terms of the policy, including, but not limited to, determination of eligibility, Pre-existing Conditions, exclusions and limitations.

Benefits for Covered Services provided for a nonemergency Hospital Inpatient Admission to a Non-PPO Hospital must be certified. When you are hospitalized in a PPO Hospital, there is no need for precertification, except as provided below. An admission for childbirth does not need certification (applicable only if you have the optional maternity rider).

EXCEPTION: Benefits for Covered Services for all Inpatient admissions to a Hospital or Treatment Center for treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency must be certified, regardless of the facility's PPO status.

a. Preadmission Certification: Benefits for all Covered Services provided for a nonemergency Hospital Inpatient admission to a Non-PPO Hospital must be precertified. In addition, benefits for Covered Services for all Inpatient admissions for the treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency must be precertified. If preadmission certification is not possible, then admission certification must be obtained within 24 hours of the admission or the next business day, whichever occurs first.

b. Admission Certification: The Administrator must be notified of a nonelective admission or emergency admission described in paragraph f. of this Part, below, within 24 hours of the admission, or the next business day, whichever occurs first, if you are admitted to a Non-PPO Hospital, or to any Hospital or Treatment Center for Inpatient treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency.

c. Notification: When certification is required, it is always your responsibility to see that the Administrator is notified. Submission of a related claim prior to hospitalization does not constitute notification. Actual notification to the Administrator may be made by the Physician, a Hospital or Treatment Center, you or someone acting on your behalf. The Administrator will notify the Physician, the Hospital, Treatment Center, you or someone acting on your behalf:

1) whether or not benefits will be certified for an Inpatient admission; and

2) the number of days which will be considered Medically Necessary for such admission.

Notification to any one of the above-named constitutes notice to you.

If the anticipated admission date changes, the Administrator must be notified.

d. Denial of Certification: If certification for an Inpatient admission to a Hospital or Treatment Center is denied because it is determined by the Administrator to be not Medically Necessary, benefits for all services which are not Medically Necessary will be denied.

e. No Request Made: If you do not request precertification of benefits and are admitted as an Inpatient by to a Non-PPO Hospital, or are admitted for any Inpatient services for the treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency, the Allowable Charges for all related Covered Services will be reduced by 25%. In addition, if the admission is determined to be not Medically Necessary, benefits for all services which are not Medically Necessary will be denied.

f. Medical Emergency Admission: The admission will be reviewed by the Administrator to determine if it was for an Emergency Medical Condition and to determine if you required Inpatient care. If you have not requested Inpatient certification within 24 hours of the admission or the next business day, the 24-hour period prior to the time of admission and the 24-hour period after such admission will be reviewed to determine if your condition and treatment would have hindered your ability to notify the Administrator. (Admission through the emergency room does not necessarily constitute an emergency admission.)

If notification of an admission by you was possible, and not made, Allowable Charges for all related Covered Services will be reduced by 25%, and benefits for all services which are not Medically Necessary will be denied.

If you receive initial Inpatient care at a Non-PPO Hospital or Treatment Center, or receive care from a Non-PPO Physician for an Emergency Medical Condition, benefits will be payable for Medically Necessary Covered Services at the PPO Deductible and Coinsurance rates for the initial care.

g. Concurrent Review: Concurrent Review is a review of an ongoing Inpatient Hospital admission to assure that it remains the most appropriate setting for the care being provided.

If additional days beyond the number of days originally certified for benefit consideration are needed, those days also must be certified in advance. The Administrator will contact the Hospital, Treatment Center or the Physician to determine the treatment plan. If additional days are Medically Necessary, benefits will be certified. The Administrator will notify the Physician, Hospital, Treatment Center, you, or someone acting on your behalf, whether or not benefit payment will be certified for additional days. If the treatment is no longer Medically Necessary beyond the length of stay certified by the Administrator, benefits for services which are not Medically Necessary will be denied.

h. Liability: Charges for services which are determined to be not Medically Necessary will be your liability, unless the Hospital, Treatment Center or Physician is a PPO Provider or is a Participating Provider with the Administrator. PPO and Participating Providers have agreed to hold you harmless for services which are determined to be not Medically Necessary.

EXCEPTION: PPO or Participating Providers may collect from you for services which are determined by the Administrator to be not Medically Necessary if, prior to services being provided, they have advised that person, in writing, and you have agreed in writing to be responsible for the payment. If written agreement cannot be obtained, verbal notification may be given by the Provider and must be documented in the patient's medical records at the time such notification is given. Use of this procedure must be limited to a specific instance and not done as a usual practice.

You will remain liable for the 25% reduction in benefits for failure to certify benefits for an admission to a Non-PPO Hospital, or for failure to certify benefits for an Inpatient admission for Mental Disease or Disorders or Alcoholism or Drug Dependency. **Any such reductions in benefits are not considered in computing the Out-of-Pocket Expense Amount.**

2. **Transplant Surgery:** All benefits for organ transplant surgeries for liver, heart, lung (single and double), combination heart-lung, pancreas, pancreas-kidney, parathyroid and bone marrow transplantation must be preauthorized in writing by the Administrator. If the Administrator authorizes benefits, they will be payable for Covered Services as outlined in Part XX. The preauthorization must include the following information:

a. the diagnosis or reason for the confinement;
b. any proposed treatment or surgical procedure; and
c. the expected days of admission.

NOTE: If the transplant surgery is not authorized by the Administrator, benefits will not be payable for services or supplies incurred for such transplant.

3. **Preauthorization:** Payment for certain procedures or services may require Preauthorization of Benefits. When required by the terms of this policy, Preauthorization will be initiated in writing by you prior to the procedure or service. This request must be accompanied by documentation from your Physician, dentist or other medical provider demonstrating the Medical Necessity of the procedure or service. This request should also indicate the location of the service. This written request should be directed to:

Nebraska Comprehensive Health Insurance Pool
Medical Support Department
P.O. Box 3248
Omaha, Nebraska 68180-0001

The Administrator will respond in writing advising you as to whether or not benefits are available. A penalty will be applied for noncompliance with this paragraph, if so indicated in the Part of this policy describing a particular benefit.

B. OTHER COST CONTAINMENT PROVISIONS:

1. **Hospital Preadmission Testing Benefit:** We pay 100% of Covered Services subject to the limitations outlined in Part XXI.B. The Deductible does not apply.

2. **Home Health Care Benefit:** Covered Services in excess of the Deductible are payable as stated in Part XIX.

3. **Diabetes Education Benefit:** Covered Services for enrollment, participation and completion of a Diabetes Patient Education Program are payable as stated in Part XXI.D.

4. **Skilled Nursing Facility Benefit:** Covered Services in excess of the Deductible are payable as stated in Part X.

PART VIII. DEDUCTIBLE, COINSURANCE, MAXIMUM OUT-OF-POCKET EXPENSE AMOUNT, AND MAXIMUM BENEFITS

A. DEDUCTIBLE: This is the amount of Allowable Charges for Covered Services you must pay each calendar year before any benefits are payable. Your PPO Provider Deductible and your Non-PPO Provider Deductible are shown on your Schedule of Benefits. Only charges for Covered Services may be used to satisfy the Deductible.

If Covered Services in a calendar year are less than your required Deductible, such Covered Services incurred during October, November and December of that year may be carried over and applied against the Deductible for the next calendar year.

In instances where no PPO Provider is available or where the policy does not specifically mention an applicable Deductible, the Non-PPO Deductible will be applied. The Deductible credited to charges by either PPO Providers or Non-PPO Providers will be credited and totaled for application to both.

B. COINSURANCE: This is the percentage of Allowable Charges which you must pay, after the Deductible is applied. Your Coinsurance percentages are shown on your Schedule of Benefits.

Except as otherwise specifically stated in this policy for Covered Services for Mental Disease or Disorders, or Alcoholism or Drug Dependency, or certain other Covered Services, or otherwise specifically limited:

for Covered Services by a PPO Provider, your Coinsurance is 20% (PPO).

for Covered Services by a Non-PPO Provider, your Coinsurance is 30% (Non-PPO).

C. OUT-OF-POCKET EXPENSE AMOUNT: Your Maximum Out-of-Pocket Expense Amount is the total amount of Coinsurance you must pay during a calendar year. The following expenses do not count toward your Maximum Out-of-Pocket Expense Amount:

1. Coinsurance paid for treatment of Mental Disease or Disorders, Alcoholism or Drug Dependency.
2. Your Deductible Amounts.
3. Physician office visit copayment amounts.
4. Prescription drug card copayment amounts, or penalty amounts.
5. The reduction amount for failure to certify an Inpatient admission.
6. Noncovered Services, or amounts in excess of the Contracted Amount.

Your Maximum Out-of-Pocket Expense Amounts for PPO and Non-PPO Providers are shown on your Schedule of Benefits. After you have incurred that amount, benefits will be paid for additional Covered Services without further application of the Coinsurance percentage for the remainder of that year, unless stated otherwise.

D. MAXIMUM CHIP BENEFITS:

1. The maximum benefit for the treatment of all conditions is a total of $1,000,000, payable from any and all CHIP policies issued during your lifetime.

2. The maximum benefits payable for the treatment of Mental Disease or Disorders, Alcoholism and Drug Dependency are $25,000 during your lifetime.

3. The maximum benefits payable for diabetes education are $500 during your lifetime.

4. Organ and Tissue Transplants: If a Preferred Transplant Center is available, and you elect not to have a covered transplant performed at such center, benefits will be limited as follows:

a. $100,000 maximum benefit per transplant; and

b. only one transplant of each type listed in paragraphs A.1. and A.2. of Part XX. Second and subsequent transplants of the same type are not covered unless performed at a Preferred Transplant Center.

The following expenses will be included in calculation of the $100,000 limit:

a. For bone marrow transplants: (1) the harvest of stem cells, whether from the bone marrow or from the blood, from a donor or from the patient; (2) processing and/or storage of the stem cells so harvested; (3) the administration of High Dose Chemotherapy and/or High Dose Radiotherapy (this step may be absent in certain applications); (4) the infusion of the harvested stem cells; and (5) hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. Expenses for services rendered more than 30 days after the infusion will not be considered in calculating the $100,000 limit.

b. For all other transplants: organ acquisition expense, donor expenses, the transplant procedure and all related expenses, including professional and facility fees, incurred during the hospital stay during which the transplant was performed.

A Preferred Transplant Center is a hospital selected by the Pool, as reflected on a list maintained by the Administrator, that has agreed to provide quality care on a cost efficient basis. One or more Preferred Transplant Centers is available for most of the transplant types listed in Part XX. Please contact the Administrator to obtain the list.

E. WAIVER OF COINSURANCE OR DEDUCTIBLE: If a provider routinely waives (does not require you to pay) or reduces the Coinsurance or Deductible for Covered Services, he or she is misstating the actual charge. The Administrator and the Pool are not obligated to pay the full percentage of the provider's original charge, but instead, will pay benefits based on the lower fee actually charged.

PART IX. BENEFITS FOR HOSPITAL SERVICES

A. OVERVIEW: Admission to a Hospital and all services must be ordered by a Physician. The following Hospital Services are Covered Services under this policy. This means that, subject to the Exclusions and Limitations set forth in Part XXIII., including determinations made by Utilization Review, benefits will be available for these services when provided to you.

B. COVERED HOSPITAL INPATIENT SERVICES:

1. **Hospital Room:** Benefits will be provided for Hospital room and board. Any special diet and all nursing services are considered included in the Hospital room charge. Benefits will be based upon the amount charged for a semiprivate room. If an intensive care unit, cardiac care or similar type of room is Medically Necessary, benefits will be based upon the charge for such room. If more than one room is used during a twenty-four (24) hour period, only one room charge will be payable and benefits will be based upon the charge for the most expensive room used during that period. When you are confined to a private room, benefits will be based upon the average charge for two-bed accommodations in that Hospital, unless you are confined to a private (isolation) room to prevent contagion and we determine that isolation was ordered, utilized and Medically Necessary.

2. **Treatment rooms:** Includes use of operating, cystoscopic, cast, recovery and other surgical treatment rooms and equipment.

3. **Anesthetics** and their administration when performed by a Hospital employee.

4. **Respiratory care including oxygen,** administered by a Certified respiratory therapist who is a Hospital employee.

5. **FDA-approved drugs,** intravenous solutions, vaccines, biologicals, and medicines which are prescribed for and administered to you while hospitalized.

6. **Blood, blood plasma, blood derivatives, or blood fractionates,** and their administration, except as in Part XXIII.B.27.

7. **Supplies, materials and equipment,** including dressings, splints and plaster casts, except "take-home" supplies and convenience items.

8. **Radiology, pathology and other diagnostic services** when billed by the Hospital.

9. **Physical therapy** when provided by a Licensed physical therapist, or Licensed physical therapist's assistant supervised by and assigned to a physical therapist.

10. **Occupational therapy services** when provided by a Licensed occupational therapist or Licensed occupational therapist assistant supervised by an occupational therapist.

11. **Speech therapy** when provided by a Licensed speech-language pathologist or registered communications assistant practicing under the direct supervision of a Licensed speech-language pathologist.

EXCEPTION: Benefits will not be provided for physical, occupational or speech therapy services which include, but are not limited to: training to compensate for perceptual impairment; cognitive training; teaching and practicing the activities of daily living; developing prevocational capacity.

C. COVERED HOSPITAL OUTPATIENT SERVICES AND AMBULATORY SURGICAL FACILITY SERVICES:

1. Payment will be made for Outpatient Hospital services or services provided by an Ambulatory Surgical Facility or other Outpatient facility, as specified in Part IX.B.2. through 8. above. For such services to be payable, they must be, in the Administrator's opinion, Medically Necessary for the specific conditions being treated.

2. Payment will be made for an observation room or postoperative holding room charge, not to exceed the average cost of a semiprivate room in Nebraska, for a period of twenty-four (24) hours. If an intensive care unit, cardiac care or similar type of room is Medically Necessary, benefits will be based upon the charge for such room. If more than one room is used during a twenty-four (24) hour period, only one room charge will be payable and benefits will be based upon the charge for the most expensive room used during that period.

PART X. BENEFITS FOR SERVICES IN A SKILLED NURSING CARE FACILITY

A. Benefits will be available for up to 30 days in a calendar year for Skilled Nursing Care Facility confinement. Charges in excess of the average semi-private room charge will not be considered Allowable Charges. Charges for more than 30 days of Skilled Nursing Care Facility confinement in a calendar year are not payable and will not be used towards satisfying the Deductible or Out-of-Pocket Expense Amount.

B. Benefits are payable only if the Skilled Nursing Care Facility confinement:

1. begins within 14 days from the last day of an inpatient hospitalization of at least three days in a row (this does not apply to readmission to a Skilled Nursing Care Facility if such readmission occurs within 60 days of the previous Skilled Nursing Care Facility discharge date);

2. is for the purpose of receiving the care for the condition which caused the hospitalization; and

3. is Medically Necessary and under the supervision of a Physician.

PART XI. BENEFITS FOR INPATIENT PHYSICAL REHABILITATION

A. Physical Rehabilitation is defined as the restoration of a person who was totally disabled as the result of an Injury or an acute physical impairment to a level of function which allows that person to live as independently as possible. A person is totally disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

1. **Benefit Provisions:** Benefits will be provided for up to sixty (60) Inpatient days per calendar year for Medically Necessary Covered Services as defined by this Part. Such benefits must be Preauthorized, as set forth in paragraph 6. of this Part. The provider must meet the requirements of the Physical Rehabilitation Program, as defined herein.

2. **Covered Hospital Services:** All services defined as Covered Services for Inpatient care by Part IX. of this policy. In addition to such services, the following will be Covered Services when provided as part of the Physical Rehabilitation Program:

a. recreational therapy;
b. social service counseling;
c. prosthetic devices and fitting;
d. psychological testing.

3. **Covered Physician Services:** All Covered Physician Services as defined by Part XII. which are provided to an Inpatient.

4. **Eligibility:** You will be eligible for the benefits provided by this Part, if you meet the following criteria:

a. Diagnoses: Services will be provided for patients who are totally disabled and who meet defined specifications for coverage as determined by us. Benefits are not available under this Part for the treatment of chronic medical conditions or a disabling disease.

b. The Covered Person must require intense daily involvement in two or more of the following treatment modalities:

1) physical therapy;
2) occupational therapy;
3) speech therapy.

c. Inpatient rehabilitation must immediately follow the acute hospitalization for the Injury, Sickness, or condition causing the disability.

d. Benefits for further rehabilitation will stop when:

1) further progress toward the established rehabilitation goal is minimal or unlikely;
2) such progress can be achieved in a less intensive setting;
3) treatment could be continued on an Outpatient basis;
4) patient no longer meets criteria for eligibility as stated in a. and b., above.

5. **Provider Requirements:** For benefits to be available for a Physical Rehabilitation Program, the provider must be accredited for Comprehensive Inpatient Rehabilitation by the Commission on the Accreditation of Rehabilitation Facilities (CARF), or otherwise approved by us.

6. **Preauthorization Procedure:** Benefits must be Preauthorized for a Physical Rehabilitation Program as set forth below. If benefits are not Preauthorized, claims for such benefits may be denied if the Covered Person's condition or the program does not meet the criteria established by this Part for a Physical Rehabilitation Program.

a. Initial Preauthorization: An initial notification must be made by the Hospital or provider to the Administrator prior to or within five (5) days of the date of admission to the program. Initial approval will be limited to a maximum of thirty (30) days. The history and physical, Physician's orders and progress notes, nurses' notes, and therapy notes are to be submitted with the Notice of Admission. If the admission is not approved by the Administrator, benefits will not be provided for those days prior to the receipt of notification.

b. Extension of Benefits: After the initial approval, requests for an extension of benefits must be submitted by the Hospital or provider to the Administrator as requested. Subsequent approvals are limited to a maximum of fifteen (15) days. The Physician's orders and progress notes, nurses' notes, therapy notes, and the request for an extension of benefits are to be submitted prior to or not later than the day through which benefits have been approved. If the extension request is not received on a timely basis and the extension is not approved by the Administrator, benefits will not be guaranteed beyond the previous approval date.

The provider will notified by telephone and in writing about the initial approval or disapproval of coverage, as well as any subsequent approval or disapproval for an extension of benefits. The Administrator will notify you in writing about the initial decision and any subsequent approval or disapproval.

PART XII. BENEFITS FOR PHYSICIAN'S SERVICES

A. COVERED PHYSICIAN'S SERVICES: Benefits will be provided to you for the following Physician's services under this Part XII., subject to the Exclusions and Limitations set forth in Part XXIII., which includes determinations made by Utilization Review. Benefits are available under this Part for Covered Services provided by a Physician or oral surgeon, Certified nurse practitioner or Certified physician assistant, within the practitioner's scope of practice, when supervised and billed for, by a Physician. Covered Services include:

1. **Surgery:** Operative invasive procedures and the treatment of fractures and dislocations provided by the Physician in charge of the case. The amount payable for an Inpatient or Outpatient major surgical procedure will include normal preoperative and postoperative care.

a. Benefits payable for procedures in which two or more physicians may be involved, shall not exceed the Allowable Charge for the procedure.

b. When multiple or bilateral surgical procedures are performed which add significant time or complexity at the same operative session, benefits will be paid for the primary procedure as determined by the Administrator. The Allowable Charge for a secondary procedure will be calculated to be 75% of the Allowable Charge had the procedure been primary. Allowable Charges for any additional procedure will be 50% of the Allowable Charge had the procedure been primary. The Administrator will determine the rate at which procedures will be reimbursed.

c. When a surgical procedure is performed in two or more steps or stages, payment will be limited to the amount provided for a single procedure.

2. **Surgical Assistance:** Benefits are payable for surgical assistance by a Physician or other practitioner listed in Part XII.A., who actively assists the operating physician. The amount payable will not exceed 20% of the PPO Physician's Reimbursement Schedule amount or the Maximum Benefit Amount for the surgery, whichever is applicable. Surgical procedures for which benefits for a surgical assistant are provided are those specifically identified by the Administrator. Such information may be obtained from the Administrator prior to surgery.

3. **Anesthesia Services:** Benefits are payable for the administration of anesthesia by a Physician or a Certified registered nurse anesthetist. Benefits are also payable for an oral surgeon or dentist with a permit issued by the state to administer general anesthesia. The amount payable for anesthesia services will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration of the anesthesia. Payment will not be made for supervision of the administration of anesthesia. Benefits will not be provided for local infiltration; nor for the administration of anesthesia by the attending or assisting surgeon (except general anesthesia for covered oral surgery and dentistry procedures, or spinal, saddle or caudal blocks related to pregnancy if you have the Maternity Rider).

4. **Nonsurgical Inpatient Hospital Visits:** Nonsurgical Inpatient care or treatment of a condition for which surgical care is not required.

5. **Concurrent Inpatient Hospital Visits:** An Inpatient Hospital visit provided by two or more Physicians on the same day is payable if, in the Administrator's opinion, the services are:

a. For unrelated nonsurgical medical diagnoses which require the services and skills of two or more Physicians with unrelated specialties; or

b. Necessary because of medical complications requiring supplemental skills not possessed by the attending surgeon or his or her assistants, and requiring nonsurgical care not related to surgery and not a part of the usual, necessary and related preoperative and postoperative care.

6. **Inpatient Consultation Service:** Benefits are payable for consultations by providers with different specialties or sub-specialties. Follow-up consultations will be paid according to the guidelines for concurrent care, as set forth in paragraph 5., above. Benefits for Inpatient consultations are subject to the following requirements:

a. is requested by the attending Physician; and

b. is required by your Sickness or Injury and beyond the special knowledge or practice specialty of the attending or other consulting Physician; and

c. the consultation includes a physical examination of you by the consulting Physician; and

d. a written report from the consulting Physician is included in your Hospital chart.

7. **Intensive Medical Service:** Unusual, repeated and prolonged attendance at your bedside is payable when required by the Sickness or Injury.

8. **Radiation Therapy and Chemotherapy.**

9. **Tissue Examinations:** Tissue examinations in connection with Covered Services for surgical procedures are payable, whether performed in a Hospital Inpatient or Outpatient facility, Ambulatory Surgical Facility, or in the Physician's office.

10. **Radiology, Pathology and Other Diagnostic Services.**

11. **FDA-approved drugs, intravenous solutions,** vaccines, biologicals, and medicines which are prescribed and administered in the Physician's office.

12. **Physician Home, Office and Outpatient Visits:** Payment will be made for such Covered Services. Renal dialysis, not billed pursuant to another procedure, is included within this service. If you receive services from a PPO Physician, you must pay a $10 copayment amount for an office visit, and benefits for the balance of the office visit charge will be paid at 100% of the Allowable Charge. If you receive services from a Non-PPO Physician, benefits will be payable subject to the Non-PPO Deductible and Coinsurance rates.

13. **Medically Necessary allergy tests** and injections of allergy extracts.

14. **Childhood immunizations,** which shall mean the complete set of vaccinations for children from birth to six years of age for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenzae type B, and chicken pox, and as otherwise provided by state or federal law. Such Covered Services shall not be subject to the Deductible.

15. **Screening mammograms:** Payment includes benefits for corresponding technical and professional interpretation fees for screening mammograms ordered by a Physician. No Pre-existing Condition waiting period shall apply to mammograms or resulting biopsies or other tests used to clarify a diagnosis. Diagnoses other than benign mammary dysplasia will be subject to such waiting period.

PART XIII. BENEFITS FOR ROUTINE CARE SERVICES

A. In addition to the Covered Physician's Services in Part XII., benefits will be allowed for the following Routine Care Services up to $150 per calendar year, and shall include:

1. office visits;

2. cardiac stress test;

3. radiology;

4. laboratory testing;

5. pap smears; and

6. immunizations, except childhood immunizations, which are payable under Part XII.

B. Benefits for the above Routine Care Services, if provided by a PPO Provider, shall not be subject to the PPO Provider Deductible or Coinsurance. If such Routine Care Services are provided by a Non-PPO Provider, such benefits shall be subject to the Non-PPO Provider Deductible and Coinsurance.

PART XIV. BENEFITS FOR COMPLICATIONS OF PREGNANCY

A. Benefits shall be paid for Medically Necessary Hospital and Physician Covered Services pursuant to Parts IX. and XII. of this policy as the result of Complications of Pregnancy, when the pregnancy had its inception after your policy date. **Complications of Pregnancy include the following:**

1. Conditions (when pregnancy is not ended) whose diagnoses are distinct from pregnancy, but are caused or adversely affected by pregnancy. These include acute nephritis, nephrosis, cardiac decompensation, and missed abortion. Similar medical conditions of an equally serious nature shall be included.

2. Cesarean section.

3. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

B. **Complications of Pregnancy do not include:**

1. False labor, occasional spotting, doctor-prescribed rest, morning sickness;

2. Post partum depression, psychosis or any other mental disease or disorder; or

3. Similar conditions which occur in a difficult pregnancy.

PART XV. BENEFITS FOR MENTAL DISEASE OR DISORDERS, OR ALCOHOLISM OR DRUG DEPENDENCY

Benefits will be provided for Covered Services provided for treatment of Mental Disease or Disorders, or Alcoholism or Drug Dependency, or any combination of these services. Benefits are subject to the exclusions and Limitations in Part XXIII., including determinations made by Utilization Review. Benefits are subject to the applicable Deductible Amount, and the Coinsurance stated in paragraph C. of this Part.

A. INPATIENT CARE: Covered Services for the acute care of Mental Disease or Disorders, or Alcoholism or Drug Dependency, or any combination of these services, shall be those Medically Necessary Hospital and Physician services listed in Parts IX. and XII. of your policy. **Benefits will be available for Inpatient treatment for up to thirty (30) days per calendar year.** Benefits for all Inpatient services must be precertified by the Administrator. Such precertification review may be performed by the Administrator or persons designated by them. A person shall be considered an Inpatient if he or she is confined to a Hospital, or to an Alcoholism and Drug Abuse Treatment Center (Treatment Center) and spends less than six hours daily outside of such facility at work, or school, or independent of direct facility supervision.

1. **Inpatient Covered Services also include:** Mental Health Services, psychological or alcoholism and drug abuse counseling services by:

    a. a qualified physician or Licensed clinical psychologist;

    b. a Licensed special psychologist, Licensed clinical master social worker, Licensed professional counselor, or Licensed Mental Health Practitioner;

    c. a psychiatric registered nurse, Certified social worker, or Certified alcohol and drug abuse counselor; working under the supervision and billed by a professional listed in a. or b., above.

All licensing or Certification shall be by the appropriate state authority.

B. OUTPATIENT CARE: Covered Services for Outpatient care shall be those Medically Necessary Outpatient services listed below. Benefits will also be available for services provided by an Outpatient Mental Disease or Disorders, or Alcoholism or Drug Dependency Treatment Program. Day treatment, partial care and Outpatient programs must be provided in a Hospital or facility which is Licensed by the Department of Health and Human Services Regulation and Licensure, and whose program is certified by the Division of Alcoholism, Drug Abuse and Addiction Services (or equivalent state agency) and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). **Benefits will be available for up to sixty (60) units of Outpatient treatment per calendar year.**

1. One unit of Outpatient treatment is defined as:

    a. one individual or group therapy session;

    b. one day in a Licensed day or partial hospitalization program provided by a facility that offers all-inclusive services and bills one charge for each Outpatient treatment day;

    c. one day in a certified Alcoholism and Drug treatment program provided by a facility that offers all-inclusive services and bills one charge for each Outpatient treatment day;

    d. one biofeedback procedure or other Medically Necessary treatment as approved by Utilization Review for treatment of Mental Disease or Disorders.

2. Outpatient Covered Services include Mental Health Services, psychological or alcoholism and drug abuse counseling services by:

    a. a qualified Physician or Licensed clinical psychologist;

b. a Licensed special psychologist, Licensed clinical master social worker, Licensed professional counselor, or Licensed Mental Health Practitioner;

c. a psychiatric registered nurse, Certified social worker, Certified alcohol and drug abuse counselor working under the supervision of, and billed by, a professional listed in 2.a. or 2.b., above.

C. PAYMENT FOR SERVICES: The Administrator has contracted with PPO Hospitals, Treatment Centers and professional providers to provide services for treatment of Mental Disease or Disorders, Alcoholism or Drug Dependency, and payment will be made as set forth in Part VI., Benefits Overview.

Your Coinsurance for Covered Services provided by PPO Providers is 50%.

Your Coinsurance for Covered Services provided by Non-PPO Providers is 60%.

You are responsible for payment of the applicable Deductible Amount, Coinsurance, charges for Noncovered Services, and charges for care in excess of the maximum day and visit limitations, above.

Out-of-state services for treatment of Mental Disease or Disorders, Alcoholism or Drug Dependency by a facility and/or provider participating with an insurer in another state affiliated with our Administrator will be payable subject to the same percentage level as PPO Providers.

D EXCLUSIONS AND LIMITATIONS: Benefits will not be provided for treatment modalities which are identified as Noncovered Services in your policy. (See Part XXIII., Exclusions and Limitations.)

E. MAXIMUM BENEFITS: The Maximum Benefits payable for you for the treatment of Mental Disease or Disorders, Alcoholism or Drug Dependency are $25,000. Coinsurance payable by you for these services will not be considered in computing the Maximum Out-of-Pocket Expense Amount under the policy.

PART XVI. BENEFITS FOR ORAL SURGERY AND DENTISTRY

A. Benefits will be provided for the following Covered Services:

1. The removal of impacted teeth in a Provider's office, Ambulatory Surgical Facility or Hospital Outpatient department.

2. Incision and drainage of cellulitis.

3. Excision of exostoses, tumors and cysts, whether or not related to the temporomandibular joint of the jaw.

4. Invasive surgical procedures of the jaw or the temporomandibular joint of the jaw.

5. Bone grafts to the jaw except those done to prepare the mouth for dentures, or for periodontal purposes.

6. Reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw required as a direct result of an accidental Injury occurring while you were a covered under this policy. Benefits for such services are limited, however, to services provided within twelve (12) months of the date of Injury. Benefits shall not be provided for such services when the dislocation or fracture occurs as the result of eating, biting or chewing.

7. Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury occurring while this policy is in effect. Benefits for such services are limited, however, to services provided within twelve (12) months of the date of Injury. Benefits shall not be provided for such services when the Injury occurs as the result of eating, biting or chewing.

8. Osteotomy performed for a gross congenital abnormality of the jaw which cannot be treated solely by orthodontic treatment or appliances. This procedure must be Preauthorized pursuant to Part VII.A.3., or available benefits will be reduced by 20%.

9. Medically Necessary radiology or laboratory or other diagnostic services for the temporomandibular joint of the jaw.

B. Benefits will be provided for Hospital Inpatient or Outpatient or Ambulatory Surgical Facility charges related to Covered Services for oral surgery and dentistry, if Medically Necessary as determined by the Administrator. In addition, benefits for Hospital Inpatient, Outpatient or Ambulatory Surgical Facility charges will be provided for Covered or Noncovered dental procedures if the Hospital admission is essential to safeguard your health due to a specific nondental physical and/or organic impairment. Benefit payments will be made as stated in Part VI.

C. **Exclusions:** No payments shall be made under this Part nor under any other Part of this policy, except for services expressly described in paragraph A., above, for:

1. Care in connection with the treatment, filling, removal, repositioning or replacement of teeth.

2. Root canal therapy or care.

3. Preparation of the mouth for dentures.

4. Treatment of the dental occlusion or temporomandibular joint of the jaw by any means or for any reason, except as described in Paragraph A. of this Part XVI. No benefits will be provided for any other treatment of Temporomandibular Joint (TMJ) Syndrome.

5. All other procedures involving the teeth or structures directly related to or supporting the teeth, including:

   a. the gums;
   b. the alveolar processes; and
   c. temporomandibular joint of the jaw.

PART XVII. BENEFITS FOR OUTPATIENT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES

Benefits are payable, subject to the applicable Deductible and Coinsurance amounts for:

A. Physical therapy when provided by a Licensed physical therapist, or Licensed physical therapist assistant supervised by and assigned to a physical therapist. Chiropractic or osteopathic physiotherapy, provided by a Licensed practitioner of the healing arts, is also a Covered Service under this Part.

B. Speech therapy when provided by a Licensed speech-language pathologist or registered communications assistant practicing under the direct supervision of a Licensed speech-language pathologist.

C. Occupational therapy provided by a Licensed occupational therapist or Licensed occupational therapist assistant, under the direct supervision of a Physician. Outpatient sessions will be limited to no more than 60 sessions per year, and an outpatient session shall be defined as a visit to the occupational therapist not to exceed 4 hours per day.

D. **Benefits shall not be provided for physical, occupational, or speech therapy services which include:**

1. training to compensate for perceptual impairment;
2. teaching and practicing the activities of daily living;
3. developing prevocational capacity.

PART XVIII. BENEFITS FOR OUTPATIENT CARDIAC AND PULMONARY REHABILITATION

A. Cardiac or Pulmonary Rehabilitation Program: Cardiac or Pulmonary Rehabilitation is defined as use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-Illness level of activity or a new and appropriate level of adjustment.

1. **Benefit Provision:** Benefits will be provided for up to six (6) consecutive weeks of Hospital Outpatient Rehabilitation Program services, to begin within four (4) months of a diagnosis set forth in paragraph 2. of this Part.

a. Covered Hospital Services: All services defined as Covered Services for Outpatient care by Part IX. of this policy. In addition to such services, the following will be Covered Services when provided as part of the Rehabilitation Program:

1) initial rehabilitation evaluation;
2) exercise sessions;
3) concurrent monitoring during the exercise session for high risk patients.

b. Covered Physician Services: All Covered Physician Services as defined by Part XII. which are provided to an Outpatient.

c. No coverage will be provided for:

1) diet or dietetic instructions;
2) smoking cessation classes;
3) medication instruction;
4) weight control and/or instruction;
5) recreational therapy, educational therapy, or forms of nonmedical self-care or self-help therapy;
6) environmental control items such as air conditioners and dehumidifiers.

2. **Eligibility:** You will be eligible for the benefits provided by this Part, if you meet the following criteria:

a. Cardiac Rehabilitation: Services will be provided for cardiac rehabilitation, at any therapeutic level, for the following diagnoses occurring during the preceding four months:

1) an acute myocardial infarction;
2) coronary bypass surgery;
3) coronary artery angioplasty;
4) heart transplant;
5) heart-lung transplant;
6) heart valve surgery.

b. Pulmonary Rehabilitation: Services will be provided for pulmonary rehabilitation, at any therapeutic level, under the following circumstances:

1) lung transplant during the preceding four (4) months;
2) heart-lung transplant during the preceding four (4) months;
3) preoperative and postoperative care for lung volume reduction surgery.

c. Benefits are not available for pulmonary rehabilitation if cardiac rehabilitation is provided at paragraph 2.a.5), above.

d. Your condition must be such that Rehabilitation can only be carried out safely under the direct, continuing supervision of a Physician and in a controlled Hospital environment.

3. **Cardiac or Pulmonary Rehabilitation Program Qualifications:** The Cardiac or Pulmonary Rehabilitation Program must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations, or as otherwise approved by us.

PART XIX. BENEFITS FOR HOSPICE CARE AND HOME HEALTH CARE

A. HOSPICE CARE: Benefits will be payable for the following services. Such services must be provided by a Hospital or related institution, Home Health Agency, Hospice or other Licensed facility which would be approved under Medicare or any applicable state law as a Hospice Care Program. Such services must be a part of a Hospice Care Program. Benefits are payable only if you are the terminally ill person. Benefits are payable for:

1. Room and board in a Hospice while you are an Inpatient.

2. Home health aide services.

3. Respite Care: Short-term Inpatient care which is necessary for you in order to give temporary relief to the person who regularly assists with the care at home. Respite care must be provided in a skilled or intermediate care nursing facility that is affiliated with the hospice that is providing services to you. Respite care in a skilled or intermediate care nursing facility need not meet our normal Medically Necessary criteria ordinarily applied to Inpatient admissions.

4. The rental of medical appliances and equipment while you are in a Hospice Care Program to the extent that such items would have been covered under the policy had you been confined in a Hospital.

5. Medical, palliative and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.

6. Counseling (other than bereavement counseling) for your immediate family, not to exceed a total maximum benefit of $500. (Your immediate family is your spouse, children, and parent.)

7. Bereavement counseling for your immediate family, not to exceed a maximum benefit of $100.

Services in excess of those that produce the above maximums will not be used in satisfying the Deductible or Out-of-Pocket Expense Amount.

In addition to the exclusions and limitations found in Part XXIII., benefits for Hospice Care will not be provided for:

1. services performed by volunteers;

2. pastoral services, or legal or financial counseling services;

3. services which are primarily for the convenience of a person other than the patient;

4. home delivered meals;

5. any maintenance therapy for non-hospice related Home Health Aide services, which is therapy not designed to improve your condition; or

6. services for mental disease or disorders.

B. HOME HEALTH CARE: Benefits will be payable for Home Health Aide Care and Skilled Nursing Care received in lieu of hospitalization and furnished under a planned program by a Home Health Care Agency Licensed to provide Home Health Care. The care must be ordered and directed by your Physician.

Benefits are payable, subject to the applicable deductible, as follows:

1. for the first 10 days of the Home Health Care in a calendar year, we will pay 100% of the Allowable Charges incurred for Home Health Care; and

2. for the next 30 days of Home Health Care in a calendar year, we will pay 80% of the Allowable Charges incurred.

Benefits are limited to the first 40 days of Home Health Care received in a calendar year. Expense incurred for Home Health Care beyond the 40th day of Home Health Care in a calendar year will not be payable, nor will it be used towards satisfying the maximum Out-of-Pocket Expense Amount or Deductible.

C. DEFINITIONS as used in this Hospice Care and Home Health Care section:

Bereavement Counseling: Counseling of your immediate family that is designed to aid them in adjusting to your death.

Hospice: A public or private agency or organization which administers and provides Hospice Care and is either:

1 Licensed or certified as such by the state in which it is located;

2. certified (or is qualified and could be certified) to participate as such under Medicare;

3. accredited as such by the Joint Commission on the Accreditation of Hospitals; or

4. meets the standards established by the National Hospice Organization.

Hospice Care Program: A coordinated, interdisciplinary program to meet the physical, physiological and social needs:

1 of terminally ill persons and their families;

2. by providing palliative (pain controlling) and supportive medical, nursing and other health services;

3. through home or Inpatient care during the sickness or bereavement.

Home Health Aide Services: Personal care services provided to you that relate to the treatment of your medical condition. Such services include, but are not limited to bathing, feeding and performing household cleaning duties directly related to you. Such services must be ordered by a Physician, and performed under the supervision of a registered nurse.

Skilled Nursing Care: Medically Necessary Skilled Nursing services for the treatment of sickness or injury which must be ordered by a Physician, and performed under the supervision of a registered nurse (R.N.) or a Licensed practical nurse (L.P.N.). The classification of a particular nursing service as skilled is based on the technical or professional health training required to effectively perform the service.

Terminally Ill: No reasonable prospect of cure and, as estimated by a Physician, having a life expectancy of less than six months.

PART XX. BENEFITS FOR ORGAN AND TISSUE TRANSPLANTATION

A. BENEFITS FOR YOU IF YOU ARE A RECIPIENT:

1. Benefits will be provided for Medically Necessary Covered Services directly related to, or resulting from a transplant of body organs or tissues as follows:

a. liver;
b. heart;
c. lung (single and double);
d. lobar lung;
e. combination heart-lung;
f. pancreas;
g. pancreas-kidney;
h. kidney (renal);
i. cornea;
j. parathyroid;
k. heart valve (heterograft); or
l. bone graft.

2. Benefits for Medically Necessary Covered Services for Allogeneic and Autologous Bone Marrow Transplants:

a. Benefits will be provided for Medically Necessary myeloablative (high dose) chemotherapy with allogeneic stem cell support only when prescribed for:

1) advanced non-Hodgkin's lymphoma;

2) advanced Hodgkin’s disease (lymphoma);

3) advanced neuroblastoma;

4) acute lymphocytic or nonlymphocytic leukemia (acute leukemia);

5) multiple myeloma treated with up to one course of chemotherapy;

6) gonadal germ cell tumor; or

7) chronic myelogenous leukemia.

b. Benefits will be provided for Medically Necessary Allogeneic Stem Cell Transplantation for primary diseases of the bone marrow for:

1) aplastic anemias and myelodysplastic syndromes: hereditary or congenital, acquired, toxic or radiation induced;

2) Wiskott-Aldrich syndrome;

3) severe congenital combined immunodeficiency;

4) thalassemia major;

5) infantile malignant osteopetrosis (Albers-Schonberg);

6) mucopolysaccharidoses: Hurler's, Hunter's, Sanfilippo, Maroteaux-Lamy, Morquio's;

7) mucolipidoses: Gaucher's, metachromatic leukodystrophy, adrenoleukodystrophy;

8) severe sickle cell disease; or

9) polycythemia vera.

c. Benefits will be provided for Medically Necessary myeloablative (high dose) chemotherapy with autologous stem cell support only when prescribed for:

1) acute lymphocytic or non-lymphocytic leukemia (acute leukemia);

2) advanced Hodgkin's disease (lymphoma);

3) advanced non-Hodgkin's lymphoma;

4) advanced neuroblastoma;

5) multiple myeloma treated with up to one course of chemotherapy;

6) Wilm's tumor;

7) gonadal germ cell tumor; or

8) stage III inflammatory breast cancer and all stage IV breast cancer.

No benefits will be provided for any other use or application of Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplant.

This part provides limited benefits for Allogeneic and Autologous Bone Marrow Transplants only for certain diseases or conditions and specifically excludes benefits for those procedures for all other diseases or conditions. You should carefully review the entire policy, including the definitions of Allogeneic and Autologous Bone Marrow Transplants, High Dose Chemotherapy and High Dose Radiotherapy. The limited benefits provided in this Part for Allogeneic and Autologous Bone Marrow Transplants are an exception to the exclusion for Investigative procedures (see Part XXIII.B.17.)

The exception of these procedures in limited circumstances from the exclusion for Investigative procedures is not intended to, and does not operate as, a waiver of the exclusion for Investigative procedures. The limited benefit provided in this Part for Allogeneic and Autologous Bone Marrow Transplants are subject to all other conditions and provisions of the policy including, without limitation, the requirement that the procedure be Medically Necessary.

3. **Additional benefits for donation of organs or tissue:** Benefits up to $20,000 will be provided for the following Medically Necessary Covered Services directly related to, or resulting from, a transplant procedure listed as covered in this Part:

a. hospital, medical, surgical or other Covered Services provided to a donor who is a Noncovered Person under this policy;

b. services provided for the evaluation of organs or tissue including, but not limited to, the determination of tissue matches;

c. services provided for the removal of organs or tissue from nonliving donors;

d. services provided for the transportation and storage of donated organs or tissue.

Benefits provided to Noncovered Persons will be secondary to benefits provided to those persons pursuant to their own hospital, medical, or major medical coverage.

B. EXCLUSIONS AND LIMITATIONS: In addition to the Exclusions and Limitations set forth in Part VIII and Part XXIII., benefits will also be subject to the specific limitations below:

1. The benefits provided by this Part XX shall not be subject to the Exclusion at Part XXIII.B.17. for services considered to be Investigative. Otherwise, the Exclusions and Limitations set forth in Part XXIII. apply to benefits for services under this Part.

2. Benefits will not be provided for High Dose Chemotherapy or Radiation Therapy when supported by bone marrow and/or stem cell transplant procedures for breast cancer, ovarian cancer and all additional diagnoses other than those identified in paragraph A.2. of this Part XX.

3. Benefits will not be provided for services for or related to human organ or tissue transplants not listed as Covered in this Part XX. Related services include administration of high dose chemotherapy or radiation therapy when supported by transplant procedures.

4. **Purchased Organs or Tissue:** Benefits will not be provided for the purchase of human organs or tissue which are sold rather than donated to the recipient.

5. **Nonhuman or Artificial/Mechanical Organs or Tissue:** Benefits will not be provided for transplantation of any nonhuman organ or tissue to a human recipient, or the implantation of an artificial/mechanical organ into a human recipient. This provision does not apply to the implantation of pacemakers.

6. Benefits are not available for an activation search fee.

C. PREAUTHORIZATION: All benefit payments for liver, heart, lung (single and double), combination heart-lung, pancreas, pancreas-kidney, parathyroid and bone marrow transplantation must be Preauthorized in writing (see Part VII.), or benefits will be denied.

D. PREFERRED TRANSPLANT CENTERS: The Administrator maintains a list of Preferred Transplant Centers. One or more Preferred Transplant Centers is available for most of the transplant types listed in this Part XX. Failure to use a Preferred Transplant center may result in reduced benefits. See Part VIII., "Maximum CHIP Benefits" for additional information.

E: DEFINITIONS AS USED IN THIS PART:

Allogeneic Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood, from a third party donor; (b) processing and/or storage of the stem cells so harvested; (c) the administration of High Dose Chemotherapy and/or High Dose Radiotherapy (this step may be absent in certain applications); (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the High Dose Chemotherapy and/or High Dose Radiotherapy.

Autologous Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood, from the patient; (b) processing and/or storage of the stem cells so harvested; (c) the administration of High Dose Chemotherapy and/or High Dose Radiotherapy (this step may be absent in certain applications); (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the High Dose Chemotherapy and/or High Dose Radiotherapy.

High Dose Chemotherapy: A form of chemotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient of an Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplant.

High Dose Radiotherapy: A form of radiotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient of an Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplant.

PART XXI. BENEFITS FOR OTHER COVERED SERVICES

A. OVERVIEW: Benefits will be payable for the Medically Necessary Covered Services and supplies listed in this Part when not covered elsewhere under this policy. Unless otherwise specifically stated, the PPO and Non-PPO Deductible and Coinsurance Amounts are applicable, based on the provider's PPO status.

B. **Hospital Preadmission Testing Benefit:** When you receive Covered Services for hospital preadmission testing, we will pay 100% of the Allowable Charge for such Covered Services subject to the limitations outlined below. The Deductible does not apply.

The following conditions apply:

1. You must be admitted to the Hospital as an Inpatient within seven days after the preadmission testing for the same condition for which the tests were performed. If not, benefits for these tests will be considered at 80% of the Allowable Charge after the applicable Deductible.

2. The preadmission tests must not be duplicated on an Inpatient basis. If a test is duplicated, benefits for the original and duplicated tests will be considered at 80% of the Allowable Charge after the applicable Deductible.

3. Any preadmission tests must be the kind that would be Covered Services if Hospital confined.

C. **Ambulance Services:**

1. to the nearest facility where you may receive appropriate care for an Emergency Medical Condition; and

2. Medically Necessary transportation within the United States by a professional nonair ambulance or on a regularly scheduled flight on a commercial airline to the nearest facility equipped to furnish the services, if your condition cannot be adequately treated in the locale where the condition occurs.

D. **Diabetes Education Benefit:** We will pay 90% of the expense you incur if you enroll, participate in, and complete a Diabetes Patient Education Program. The Deductible does not apply.

Benefits are subject to the following limitations:

1. The maximum amount payable is $500 during your lifetime.

2. You must take the Diabetes Patient Education Program.

3. You have diabetes.

4. Charges in excess of the maximum listed in (1) above will not be used towards satisfying the Deductible or Maximum Out-of-Pocket Expense Amount.

Diabetes Patient Education Program: A program of instruction which:

1. is provided by a Physician, a registered nurse, Licensed pharmacist, a dietitian or other health professional;

2. is designed to teach diabetic patients and their families

   a. to understand the diabetic disease process,
   b. to manage the daily diabetic therapy, and
   c. to avoid frequent hospital confinements and complications;

3. meets any standards which the state or local diabetes agency recognizes as an acceptable program. The instructor of such program must be certified by the American Association of Diabetes Educators.

It does not include a program which is mainly for the purpose of weight reduction.

E. **Artificial eyes or prosthetic limbs.**

F. **Oxygen and equipment** for its administration, and inhalation therapy.

G. **Home Medical Equipment:** Rental or initial purchase, whichever is least costly, of certain items of Medically Necessary Home Medical Equipment when prescribed by a Physician. Benefits for rental of Home Medical Equipment will not exceed the cost of purchasing of such equipment unless otherwise approved by the Administrator. We may Preauthorize a second or subsequent purchase of an item of Home Medical Equipment, if such purchase is made necessary by a significant change in your condition, or as otherwise determined by us to be reasonable and necessary. Benefits will not be provided for the repair, maintenance or adjustment of Home Medical Equipment or for sales tax on the purchase of such equipment unless repair or maintenance is determined by us to be reasonable, necessary or cost-effective. Benefits will not be provided for Home Medical Equipment rented, purchased from or used while confined to a Hospital, a skilled nursing facility, an intermediate care facility, a nursing home or any other Licensed residential facility if such equipment is usually supplied by the facility.

H. **Renal Dialysis:** Services for renal dialysis including all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided for six sessions of dialysis training or counseling. Such benefits will be paid for a maximum of 30 months or until Medicare assumes responsibility for benefits, or as governed by Medicare requirements.

I. **Home Infusion Therapy.**

J. **One set of eyeglasses or contact lenses** or replacement of one set of eyeglasses or contact lenses, because of a change in prescription of at least one diopter as a direct result of ocular surgery or ocular Injury, if ordered by a Physician. Such Covered Services must be provided within 12 months of the date of the ocular surgery or Injury.

K. **Chiropractic or osteopathic manipulations or adjustments,** provided by a Licensed practitioner, within his or her scope of practice.

PART XXII. RX NEBRASKA PRESCRIPTION DRUG CARD PROGRAM

A. OVERVIEW: This Part provides benefits for the purchase of Medically Necessary prescription medications and other specified Covered Services purchased from a pharmacy, as listed on Schedule A, below. This Part does not apply to prescription medications and services prescribed or provided during or for Inpatient Hospital or Treatment Center care.

Benefits are available for a quantity of medication sufficient to treat the acute phase of an Sickness, or in the case of maintenance medication, a 30-day supply, unless otherwise limited. Benefits will be available for the purchase of a reasonable quantity of covered supplies. You may obtain Covered Services from either a Participating or Non-Participating Pharmacy.

The Rx Nebraska network of Participating Pharmacies is separate from the PPO network. Please refer to your Rx Nebraska directory.

B. **Participating Pharmacies:** When you obtain Covered Services from a Participating Pharmacy, and present your Rx Nebraska Drug Card at the time of purchase, you are responsible to pay the Copayment amount directly to the dispensing Participating Pharmacy. Participating Pharmacies will not bill or collect any amount for Covered Services from you in excess of this Copayment amount, except as provided in paragraph D, Generic Drugs.

When you obtain Covered Services from a Participating Pharmacy, and present your Rx Nebraska Drug Card at the time of purchase, the Participating Pharmacy's charge for the Covered Service will be the lesser of: 1) the usual retail price; 2) the maximum allowable charge (MAC), plus dispensing fee; or 3) the average wholesale price (AWP) minus a negotiated percentage of AWP plus dispensing fee. If the pharmacy's charge is less than the Copayment amount, you are responsible for payment of the charge.

If you do not present your Rx Nebraska Drug Card to the Participating Pharmacy at the time of purchase, the Participating Pharmacy may collect their usual retail price for the item from you. You are responsible to make payment of this amount, and to submit the claim directly to the Administrator for benefit payment. Benefits will be provided to you in an amount equal to the billed charge less the Copayment amount and less a 25% penalty amount.

C. **Non-Participating Pharmacies:** When you obtain Covered Services from a Non-Participating Pharmacy, you will be responsible to make payment to the pharmacy of their usual retail price for the Covered Service. You are required to submit the claim directly to the Administrator for benefit payment. Benefits will be provided to you in an amount equal to the billed charge less the Copayment amount and less a 25% penalty amount.

D. **Generic Drugs:** Whenever appropriate, generic drugs will be used to fill prescriptions. If the prescribing Physician or Dentist does not indicate "no drug product substitution" for the prescription, a Participating Pharmacy may fill it with the generic drug. If you refuse a generic drug in favor of a brand name drug, the Participating Pharmacy may then charge you for the difference in cost between the generic drug and the brand name drug, and such difference will be your responsibility. This difference will be in addition to the Copayment amount.

E. In the event that the Administrator determines that a person's utilization of a prescription medication in a 6-month period exceeds certain threshold amounts, and that such utilization reasonably demonstrates a pattern of usage that is not Medically Necessary, we reserve the right to limit such person to a Participating Pharmacy of their choice for obtaining Covered Services. If the person is limited to such a Pharmacy, no benefits will be provided for prescription medications obtained from any other pharmacy.

F. CLAIM FILING:

1. **Submission of Claims by a Participating Pharmacy:** Participating Pharmacies will submit the claim for your purchase of Covered Services, if you present your Rx Nebraska Drug Card at the time of purchase.

2. **Submission of Claims by the Covered Person:** You must submit a claim for Covered Services purchased from a Non-Participating Pharmacy, or for purchases from a Participating Pharmacy when the Rx Nebraska Drug Card is not presented at the time of purchase.

A complete itemized statement identifying the Covered Service must be attached to an appropriate claim form. To process a claim, the Administrator must always have your identification number, an itemized statement identifying each item purchased, prescription number, quantity and date purchased, and amount charged. They are entitled to any additional information needed to process the claim.

3. **Time Limit for Filing a Claim:** A claim should be filed within 90 days of the time the services are provided, or as soon thereafter as is reasonably possible. If you do not file a claim within 18 months of the date of service, and it was reasonably possible to do so, benefits will not be paid.

4. Claims should be sent to: Blue Cross and Blue Shield of Nebraska, P. O. Box 3248, Omaha, Nebraska 68180-0001.

G. PRE-EXISTING CONDITIONS:

The benefits provided by this Part **are not** subject to any Exclusion or Limitation for Pre-existing Conditions that may be applicable to other benefits provided by the policy. Payment of benefits pursuant to this provision shall not waive such Exclusions or Limitations as they apply to other benefits provided by the policy.

H. ADDITIONAL PROVISIONS:

1. By accepting benefits under this policy, you authorize and direct the Participating Pharmacies and ProPar Services, Inc. to furnish copies of all information and records concerning the Covered Person to the Administrator.

2. Neither the Administrator or the Comprehensive Health Insurance Pool, will be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of prescriptions) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any prescription or supply.

3. If you have prescription drug coverage under more than one health plan, the coverage first used (for the purchase) becomes the primary coverage. When another coverage (or other drug card) is used first, the out-of-pocket expense you incur for the purchase may be submitted for consideration under this CHIP policy. Benefit payment will be subject to the benefit reduction provision stated at Part XXIII.F.1. Please submit an itemized statement for the service, as well as evidence of your out-of-pocket expense or other plan's benefit. No additional penalty amount will be imposed for your submission of a paper claim when this policy is paying as a secondary payer for these services.

4. Benefits provided pursuant to this Part are subject to all other terms, conditions, definitions and limitations of the policy which are not in conflict with this Part.

I. DEFINITIONS:

The following definitions are provided in place of or in addition to the definitions found in Part XXVI. of this policy.

Copayment: The amount payable by you for Covered Services identified on Schedule A. The Copayment amount is indicated on your Schedule of Benefits.

Covered Services: Prescription medications, services and supplies identified on Schedule A., for which benefits are payable.

Noncovered Services: Prescription medications**,** services and supplies as identified on Schedule B., for which benefits are not payable, or according to the terms of the policy.

Non-Participating Pharmacies: Licensed pharmacies which have not entered into written agreements with ProPar Services, Inc.

Participating Pharmacies: Licensed pharmacies which have entered into written agreements with ProPar Services, Inc.

ProPar Services, Inc.: A wholly owned subsidiary of Blue Cross and Blue Shield of Nebraska. Blue Cross and Blue Shield of Nebraska reserves the right to assign the operation of this program to a successor corporation which will be a subsidiary of Blue Cross and Blue Shield of Nebraska and Aware Integrated Inc., a holding company for Blue Cross and Blue Shield of Minnesota, and Prime Therapeutics, Inc. The provisions of this policy Part shall be conformed accordingly.

SCHEDULE A

Covered Services

1. FDA-approved drugs requiring a Physician's or Dentist's prescription, dispensed in compliance with a permit to conduct a pharmacy or as otherwise permitted by state law. All FDA-approved drugs shall have a valid NDC number. Drugs listed on Schedule B shall not be Covered Services.

2. Compound prescriptions that contain at least one FDA-approved prescription ingredient and have a valid NDC number.

3. FDA-approved AIDS therapy drugs and anti-rejection drugs (immunosuppressants).

4. Cosmetic alteration drugs.

   - Retin-A, Differin, Azelex, Renova (covered through age 40 with preauthorization).

5. Covered diabetic supplies including but not limited to needles, syringes, test strips, lancets and swabs.

6. Covered ostomy supplies including, but not limited to belts, dressings, pouches and skin barrier.

7. Injectables, not to include home infusion.

8. Insulin.

9. Oral contraceptives.

10. Prescription vitamins and prescription prenatal vitamins.

    Erectile dysfunction agents including: Viagra, Caverject, Muse and Alprostadil.

    - Viagra (sildenafil) is limited to 8 pills per 30 days, and is a Noncovered Service for males through the age of 18, and for all females.

The following drugs require preauthorization of benefits:

- Dexedrine. This drug is covered through age 21. After age 21, preauthorization is required.
- Growth hormones.
- IVIG.
- Regranex.
- Retin-A, Differin, Azelex, Renova (covered through age 40).

SCHEDULE B

Noncovered Services

1. Diet or appetite suppressant drugs.

2. Dietary supplements (nutritional supplements).

3. Drugs or medicinals for treatment of fertility/infertility.

4. Health or beauty aids.

5. Home infusion therapy. (Covered under the medical contract only.)

6. Home Medical Equipment or devices of any type, including, but not limited to: contraceptive devices; therapeutic devices; or artificial appliances.

7. Investigative drugs or drugs classified by the FDA as experimental.

8. Nicotine Polacrilex (Nicorette), Nicotine Transdermal System (Habitrol, Nicoderm, Nicotrol, ProStep) or any other medication whose primary purpose is to treat nicotine addiction.

9. Non-prescription medications.

10. Over-the-counter medications.

11. Prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI).

12. Topical Minoxidil (Rogaine).

PART XXIII. EXCLUSIONS AND LIMITATIONS

Benefits are not provided by this policy for the following:

A. Services not considered by the Administrator to be payable after consideration by Utilization Review. Benefits will not be provided for services, procedures, drugs, supplies or Home Medical Equipment, which are determined by Utilization Review to be not Medically Necessary.

B. Services not specifically covered by this policy, nor amounts above charges for Covered Services. If a Non-Covered Service is provided to you, the responsibility for payment rests with you. Non-Covered Services include, but are not limited to, any service for, or related to:

1. services or supplies which are not actually provided while the policy is in force;

2. orthodontics; dental splints or appliances; or the treatment, filling, removal, repositioning, replacement, or the movement of the teeth or tissues next to the teeth, except due to injury;

3. injuries or sickness covered by Workers' Compensation or employers' liability laws, whether or not you assert rights to such coverage;

4. care or treatment in a hospital owned or operated by the United States Government or any of its agencies, unless you are obligated to pay such charges;

5. eye refractions or eyeglasses or contact lenses except as allowed in Part XXI.J.;

6. refractive corneal surgery (except for corneal grafts); or eye exercises or visual training (orthoptics);

7. private duty nursing;

8. loss that results from an act of declared or undeclared war, or sustained while performing military service (upon notice to us of entry into a service, the pro rata premium will be refunded);

9. routine audiological examinations; audiant bone conductors or hearing aids and their fitting;

10. normal childbirth, normal pregnancy (unless you purchase the optional maternity rider); voluntarily induced abortion; or care of a newborn infant, except as specifically provided in Part VI.9. of this policy;

11. complications of pregnancy when the pregnancy had its inception before your policy date;

12. gender transformations or changes, or the promotion of fertility, including but not limited to:

    a. any procedure, treatment or drug designed to facilitate the production or transit of the ovum and/or sperm, and/or the implantation of the fertilized ovum,

    b. reversal of surgical sterilization, and

    c. direct attempts to cause pregnancy by hormone therapy, artificial insemination, invitro fertilization or embryo transfer;

13. routine physical examinations or tests, except as specifically provided in Parts XII. and XIII.;

14. self-inflicted injuries or sickness; or charges as a result of your engagement in an illegal occupation or your commission of or attempt to commit a felony;

15. expenses incurred for the transplant of a part of your body to the body of another;

16. treatment of a pre-existing condition until the policy has been in force at least six months;

17. investigative or experimental services or supplies, or for any related services or complications;

18. any expenses incurred that are covered by any local, state or federal programs;

19. loss that is covered by any other insurance plan;

20. therapy which is primarily of recreational or educational nature; music therapy; work-hardening therapy; pre-vocational training or forms of nonmedical self-care or self-help training, and any related diagnostic testing;

21. treatment and diagnostic procedures primarily for obesity or weight reduction or modification, regardless of diagnosis, or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery;

22. transplant surgery which is not preauthorized;

23. custodial care;

24. breast reduction or augmentation;

25. medical supplies, devices or equipment provided for the convenience or personal use of the patient;

26. charges made separately for services, supplies, and materials when such services, supplies, and materials are considered by the Administrator to be included within the charge for a total service payable under this policy;

27. services by or for blood donors, except administrative charges for blood used for you furnished to a Hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood;

28. charges in excess of the Contracted Amount or Maximum Benefit Amount;

29. charges by a health care provider for services which are not within his or her scope of practice;

30. Hospital or Physician charges for standby availability; charges made for filling out claim forms or furnishing any other records or information or special charges such as dispensing fees, admission charges, Physician's charge for Hospital discharge services, after-hours charges over and above the routine charge, administrative fees, technical support or utilization review charges which are normally considered to be within the charge for a service;

31. personal expenses while hospitalized, such as guest meals, television rental and barber services; charges made while you are temporarily out of the Hospital;

32. cognitive training which is a therapeutic intervention aimed at retraining or facilitating the recovery of mental and information processing skills including perception, problem-solving, memory storage and retrieval, language organization and expression;

33. genetic treatment or engineering, including any service performed to alter or create changes in genetic structure;

34. equipment for purifying, heating, cooling or otherwise treating air or water; the building, remodeling or alteration of a residence; the purchasing or customizing of vans or other vehicles;

35. exercise equipment;

36. orthopedic shoes, foot supports or devices such as arch or heel supports;

37. treatment or removal of corns, callosities, or the cutting or trimming of nails;

38. nutrition care or supplements, supplies or other nutritional substances;

39. food antigens and/or sublingual therapy;

40. lodging or travel, even though prescribed by a Physician for the purpose of obtaining medical treatment, except for ambulance services as provided under Part XXI.C.;

41. interest, sales or other taxes or surcharges on Covered Services, drugs, supplies or Home Medical Equipment. This shall include taxes or surcharges levied by governmental bodies or subdivisions who do not have jurisdiction over this policy;

42. services for medical treatment and/or drugs, whether compensated or not, which are directly related to, or resulting from your participation in a voluntary, investigative test or research program or study;

43. services required by an employer as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests.

C. Mental Health Services, psychological or alcoholism and drug abuse counseling services by persons other than:

1. a qualified Physician or Licensed clinical psychologist;

2. a Licensed special psychologist, Licensed clinical master social worker, Licensed professional counselor, or Licensed Mental Health Practitioner;

3. a psychiatric registered nurse, Certified social worker, or Certified alcohol and drug abuse counselor; working under the supervision and billed by a professional listed in 1. or 2., above.

Programs of codependency, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction are not Covered Services. Benefits are not available for residential or day rehabilitation services for Mental Disease or Disorders, or residential, halfway house or methadone maintenance programs for alcoholism or drug dependency, nor will they be provided for programs ordered by the Court which are not Medically Necessary as determined by the Administrator.

D. No benefits will be paid for any service or supply which would be provided without cost to you in the absence of insurance covering the charge. Any charge above the charge that would have been made if no coverage existed, or any service which is normally furnished without charge will be treated as a service for which there is no legal obligation to pay. No benefits will be paid for any services performed by a member of your immediate family.

E. Benefits will not be provided for services and procedures, and any drugs, supplies or Home Medical Equipment which are considered by the Administrator to be obsolete, or for any related services. Procedures will be considered to be obsolete when such procedures have been superseded by more efficacious treatment procedures, and are generally no longer considered effective in clinical medicine.

F. LIMITATIONS:

1. **Reduction Due to Other Coverage:** Benefits otherwise payable under this policy shall be reduced by all amounts paid or payable through any other health insurance or insurance arrangement and by all hospital and medical expense benefits paid or payable under any Workers' Compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or no-fault, or any state or federal law or program.

2. **Mental Disease or Disorders, Alcoholism or Drug Dependency Limitations:** Benefits for mental diseases or disorders, alcoholism or drug dependency are subject to limitations as shown in Part XV.

3. **Organ and Tissue Transplantation:** Benefits for Organ and Tissue Transplantation are subject to limitations as shown in Parts VIII. And XX.

4. **Hospice Care and Home Health Care:** Benefits for Hospice Care and Home Health Care are subject to the limitations shown in Part XIX.

5. **Oral Surgery and Dentistry:** Benefits for Oral Surgery and Dentistry are subject to the limitations shown in Part XVI.

G. COSMETIC OR RECONSTRUCTION SURGERY LIMITATIONS: Benefits for cosmetic or reconstructive surgery are payable only if for or due to:

1. injuries received while this policy is in force;

2. conditions that result from surgery for which benefits were paid under this policy.

H. DUPLICATION OF BENEFITS: If a single item of expense is payable under more than one provision of this policy, payment will be made only under the provision providing the greater benefit. This does not apply to Part VII. If benefits are payable at a reduced percentage pursuant to Part VII., we will pay benefits under the provision providing the smaller benefit.

PART XXIV. HOW TO FILE A CLAIM

A. NOTICE OF CLAIM/PROOF OF LOSS: You must give the Administrator written notice of claim when you have received health care services for which this policy provides benefits. The claim must give written proof of the services provided. The claim may be filed by you, the Hospital, the Physician or whoever provided the service. To process a claim, it is necessary to include your name and policy number as shown on the Schedule of Benefits or Identification Card. Notice should be mailed to the Administrator.

You must give written proof of your loss within 90 days after the date or as soon as you can. Proof must, however, be furnished no later than 18 months of the date of service it is otherwise required, except in the absence of legal capacity.

IT IS SUGGESTED THAT ALL CLAIMS BE FILED WITH THE ADMINISTRATOR AS SOON AS POSSIBLE AFTER EXPENSES ARE INCURRED.

PLEASE NOTE: CERTAIN EXPENSES MUST BE PREAUTHORIZED BY THE ADMINISTRATOR TO OBTAIN BENEFITS.

PART XXV. GENERAL POLICY PROVISIONS

A. ENTIRE CONTRACT CHANGES: This policy, and any attachments, is the entire contract of insurance between you and us. Only the Board of Directors of the Nebraska Comprehensive Health Insurance Pool can approve a change. Any such change must be shown in your policy. No agent may change this policy or waive any of its provisions.

B. GRACE PERIOD: Unless not less than 30 days prior to the premium due date we have delivered or mailed to your last known address written notice of our intent not to renew this policy, a 31-day grace period for premium payment will be allowed. This means that if a renewal premium is not paid by the date it is due, it may be paid during the following 31 days. Your policy will remain in force during this grace period.

C. TIME LIMIT ON CERTAIN DEFENSES: After two years from the date you become covered under this policy, we cannot use misstatements, except fraudulent misstatements in your application, to void coverage or deny a claim for loss that happens after the two-year period.

No claim for loss incurred after six months from the date you become covered under this policy shall be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of your coverage.

The above portions also apply to riders attached to this policy. In applying them the word "rider" will be used for the word "policy."

D. APPEAL PROCESS: If benefits have been denied you may, within 60 days from receipt of the denial, appeal to the Administrator for reconsideration of the determination. The Administrator shall issue its decision after reconsideration in writing explaining the basis of the determination. If you disagree with the decision made by the Administrator, you may make an appeal to the Grievance Committee of the CHIP Board of Directors. This request should be made in writing, within 60 days of the decision, and addressed to the Grievance Committee, at the Administrator’s address.

E. RECOVERY OF NONCOVERED SERVICES: If benefits are paid which were not for Covered Services, we may seek reimbursement as provided by law. Duplicate or erroneous payments not recovered will be considered as benefits paid under the policy and will remain applied to your policy Maximum Benefits. Payment for a specific service under this policy shall not make us liable for further payment for the same condition.

F. SUBROGATION RIGHTS:

If you are injured because of a third party's wrongful act or negligence:

1. We will pay policy benefits for that injury, subject to the conditions that you:

   a. agree in writing to our being subrogated to any recovery or right of recovery you have against that third party;

   b. will not take any action which would prejudice our subrogation rights; and

   c. will cooperate in doing what is reasonably necessary to assist us in any recovery.

2. We will be subrogated only to the extent of policy benefits paid because of that injury.

Subrogation means our right to recover any policy payments:

1. made because of an injury to you caused by a third party's wrongful act or negligence; and

2. which you later recover from the third party or the third party's insurer.

Third party means another person or organization.

G. PHYSICAL EXAMINATION AND AUTOPSY: We, at our expense, may have you examined when and as often as is reasonable while a claim is pending. We may also have an autopsy done (at our expense) where it is not forbidden by law.

H. MISSTATEMENT OF AGE: If your age has been misstated, all benefits payable shall be in the amount of a prorata reduction between the actual age and stated age.

I. LEGAL ACTIONS: You can not bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can not start such an action more than three years after the date proof of loss is required.

J. ILLEGAL OCCUPATION: We shall not be liable for any loss to which a contributing cause was your commission of, or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation.

K. INTOXICANTS AND CONTROLLED SUBSTANCE: We shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.

PART XXVI. DEFINITIONS

"Our," "we," "us" means the Nebraska Comprehensive Health Insurance Pool, or the Administrator or other person designated to act on our behalf.

"You," "your" means the person named as the insured on the Schedule of Benefits.

Administrator: The insurer shown on the policy schedule as the Administrator, who has the power to determine membership eligibility, benefits, and to interpret the terms of this policy.

Alcohol or Drug Treatment Center (Treatment Center): A facility Licensed by the Nebraska Department of Health and Human Services Regulation and Licensure, whose program is certified by the Division of Alcoholism Drug Abuse and Addiction Services (or equivalent state agency), or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not Licensed as a Hospital, and provides Inpatient or Outpatient care, treatment, services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of dependency or addiction to the use of alcohol or drugs.

Allowable Charge: The Allowable Charge for Covered Services provided by a Hospital or other institutional facility is the lesser of the Contracted Amount or the billed charge. The Allowable Charge for a Covered Service provided by a PPO Physician or other PPO Provider is the lesser of the billed charge or the Reimbursement Schedule Amount. If a Reimbursement Schedule Amount is not established for a Covered Service, the Allowable Charge is the lesser of the Maximum Benefit Amount or the billed charge. The Allowable Charge for any other Covered Service is the billed charge. The Allowable Charge is the amount on which your Coinsurance is based.

Ambulatory Surgical Facility: A certified facility which provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be Licensed as a health clinic as defined by state statutes, but shall not include the offices of private Physicians or dentists whether for individual or group practice.

Calendar Year: Begins on January 1 and ends on December 31.

Certified/Certification: Successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be in compliance when they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the policy provisions or state law.

Cosmetic: Services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Service: Medically Necessary services and supplies listed in this policy, and provided to you while this policy is in effect. The services and supplies must be ordered or prescribed by a Physician as needed for diagnosis or treatment. Expense for a service or supply is considered incurred on the date the service or supply is received.

Custodial Care: Care given to a patient who:

1. is mentally or physically disabled; and

2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home; and

3. is not under active and specific medical, surgical or psychiatric treatment which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance, within a reasonable time, which will not exceed one year in any event.

A Custodial Care determination may still be made if the patient is under the care of a Physician; or services are being ordered to support and generally maintain the patient's condition, or provide for the patient's comfort, or assure the manageability of the patient; or the ordered services are being administered by a registered or Licensed practical nurse.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.

Generic Drug: A drug: (a) that meets all Federal Drug Administration standards; (b) that does not have a registered trademark; and (c) whose name can be used by more than one drug company.

Home Health Care Agency: (a) a hospital; (b) a visiting nurse association Licensed by the state; or (c) a nonprofit or public home health agency or organization Licensed as such by the state.

Home Health Care: Continued care and treatment in the home of an insured person who is under the care of a Physician and who would need continued hospital or Skilled Nursing Care Facility confinement without the Home Health Care.

Home Infusion Therapy: Medically Necessary Covered Services and supplies required for administration of a Home Infusion Therapy regimen when ordered by a Physician and provided by a Licensed Home Infusion Therapy Provider.

Home Medical Equipment: Equipment and supplies which are Medically Necessary to treat an Injury or Sickness, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Home Medical Equipment includes such items as prosthetic devices, orthopedic braces, crutches, wheel chairs, hospital beds and respiratory or ventilation devices. It does not include sporting equipment or items purchased for the convenience of the family.

Hospital: A Hospital is an institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment services with twenty-four (24) hour per day nursing services, to two or more nonrelated persons with a Sickness, Injury or Pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

Injury: Accidental physical or bodily harm, received while your policy is in force, or, if a Pre-existing Condition, causes loss beginning more than six months after the policy date.

Inpatient: A patient admitted to a Hospital for bed occupancy for more than 24 hours to receive necessary medical care.

Investigative: A technology for a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been scientifically validated as set forth below**:**

1. The technology for drugs, biologicals, products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated.

2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects the health outcomes.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Health Care Financing Administration (HCFA) Technology Assessments and United States Food and Drug Administration (FDA) approvals.

3. The technology must improve the net health outcome.

4. The technology must improve the net health outcome as much as or more than established alternatives.

5. The improvement must be attainable outside the investigational settings.

The Administrator will determine whether a technology is Investigative.

Licensed (Licensure): Permission to engage in a health profession which would otherwise be unlawful in the State where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title. In regard to facilities, Licensed shall mean appropriate approval and licensing by the Department of Health and Human Services Regulation and Licensure (or equivalent state agency).

Maximum Benefit Amount: A benefit amount which is an amount determined by the Administrator to be reasonable. The maximum amount will be the amount agreed upon between the Administrator and their Participating Providers for the Covered Service. If no amount has been established for a Covered Service, they may consider the charges submitted by providers for like procedures, a relative value scale which compares the complexity of services provided, or any other factor deemed necessary.

Medically Necessary: Services, treatments, procedures, drugs, supplies or Home Medical Equipment provided by the Physician, Hospital or other health care provider, in the diagnosis or treatment of the Covered Person's Sickness, Injury, Pregnancy or Mental Disease or Disorders or Alcoholism or Drug Dependency, which are:

1. Appropriate and cost effective for the evaluation and treatment of the patient's condition, without adversely affecting his or her medical condition; and

2. Provided in the most appropriate setting and at the most appropriate level of services. The most appropriate setting and most appropriate level of services is that setting and that level of services which is the most cost effective without adversely affecting the Covered Person's medical condition. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms or condition must require that treatment cannot be safely provided in a less intensive medical setting; and

3. Consistent with the prevailing professionally recognized standards of medical practice in the medical community or jurisdiction where the service is performed; and

4. Not provided primarily for the convenience of any of the following:

   a. the Covered Person;

   b. the Physician;

   c. the Covered Person's family;

   d. any other person or health care provider; and

5. Not considered to be unnecessarily repetitive when performed in combination with other diagnoses or treatment procedures.

Utilization Review will determine whether services provided are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Physician.

Mental Health Services or Practice: The provision of treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental Health Practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law) for the purpose of referral or consultation.

Mental Health Practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, injury, or deformity, diagnosing major Mental Disease or disorder except in consultation with a qualified Physician or Licensed clinical psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified Physician or Licensed clinical psychologist, or using psychotherapy to treat the concomitants of organic illness except in consultation with a qualified Physician or Licensed clinical psychologist.

All Mental Health Services must be provided under appropriate supervision and consultation requirements as set forth by state law.

Noncovered Services: Services which are not payable according to the terms of this policy.

Non-Participating: A provider which has not contracted with the Administrator.

Non-PPO Hospital: A Hospital which has not contracted with the Administrator to provide services as a part of the PPO Provider network.

Non-PPO Physician: A Licensed Physician who has not contracted with the Administrator as a part of the PPO Provider network.

Non-PPO Provider: A Licensed practitioner of the healing arts, or qualified provider of health care services, supplies, or Home Medical Equipment who has not contracted with the Administrator as a part of the PPO Provider network.

Normal Childbirth or Normal Pregnancy: Childbirth or pregnancy free of complications.

Complications of Pregnancy:

1. Conditions (when pregnancy is not ended) whose diagnoses are distinct from pregnancy, but are caused or adversely affected by pregnancy. These include acute nephritis, nephrosis, cardiac decompensation, and missed abortion. Similar medical conditions of an equally serious nature are included.

2. Cesarean section.

3. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy **do not** include:

1. False labor, occasional spotting, doctor-prescribed rest, morning sickness.

2. Post partum depression, psychosis or any other mental disease or disorder.

3. Similar conditions which occur in a difficult pregnancy.

Participating Provider: A Licensed practitioner of the healing arts, or qualified provider of health care services, supplies, prescription medicine or Home Medical Equipment who has contracted with our Administrator to provide services, supplies, prescription medication or Home Medical Equipment.

Physician: A person, holding an unrestricted license and duly authorized to practice medicine and surgery and prescribe drugs. He or she must be providing services within the scope of his or her license.

Pre-existing Condition: A condition which manifested itself within six months before the policy date, in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment, or for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding the policy date.

Preferred Provider Organization: A panel of hospitals, physicians and other providers who participate in a panel developed by the Administrator to more effectively manage health care costs.

PPO Hospital: A Hospital which contracts with the Administrator to provide services as a part of the PPO Provider network.

PPO Physician: A Physician who has contracted with the Administrator to provide Covered Services as a part of the PPO Provider network.

PPO Provider: Any other Licensed practitioner of the healing arts, or qualified provider of health care services, supplies or Home Medical Equipment who has contracted with the Administrator to provide services, supplies, or Home Medical Equipment as a part of the PPO Provider network.

Sickness: A illness, disease or physical condition which deviates from or disrupts normal bodily function or body tissues in an abnormal way, and is manifested by a characteristic set of symptoms. A sickness is one which causes loss beginning while this policy is in force, or, if a Pre-existing Condition, causes loss beginning more than six months after your policy date.

Skilled Nursing Care Facility: A place Licensed to provide skilled nursing care to resident persons. It must have a registered graduate nurse (RN) on call 24 hours a day.